
From: Adam Staten <adamstaten@gmail.com>
Sent: 10/27/2014 1:45:39 PM -0500
To: billy.hindmon@gmail.com
Subject: Webber
Attachments: new doc 7.pdf

Sent from my iPhone

**GOVERNMENT'S
EXHIBIT**

**EXHIBIT No. 2616
1:18-CR-11**

Pharmacy Order Form

Topical Compounded Creams

REF# _____

PATIENTS INFO:**PRIMARY INSURANCE INFO:**

NAME: Alyssa Weber		Company Name:	
DOB: 6/11/1985		Subscriber ID:	Group #:
DAY TIME PHONE #: 931-216-9340		Rx BIN #:	Rx GRP:
DAY TIME DELIVERY ADDRESS: 41684 gipson st. #a Fort Campbell. Ky 42223		Insured Name:	

Indicate which type of conditions you are seeking treatment for by initialing next to the formulas below. (Limit of 5 Per Patient)

SCAR, PAIN, & SKIN CARE MANAGEMENT SOLUTIONS:

Topical Pain Management _____

Topical Scar Therapy ☒

Topical Wound Management _____

Topical Psoriasis Treatment _____

Topical Eczema Treatment ☒Topical Stretch Mark ☒

Topical Burn Cream _____

Topical Nail Fungus _____

General Wellness Tablets _____

Topical Anti-Aging/Wrinkle _____

Topical Nausea Cream _____

Topical Gout Management _____

Topical Migraine Cream _____

Psoriasis Shampoo _____

To better evaluate the effectiveness of this compounded medication, I am requesting that I receive a freshly compounded prescription every 30 days. AW

I agree that the delivery of my medications may be left at my home if someone is not available to sign for them.

By signing below, I am formally requesting treatments for the above conditions that the above prescription formulas in the quantity indicated and refill amount be written for me by a medical professional. I also consent to the pharmacy using the insurance info I have supplied to file a claim for approval of these prescription formulas and they be shipped to my residence.

PATIENT SIGNATURE:Alyssa Weber**DATE:**10/24/14

The FDA does not review any compounded medication for safety or efficacy.

Product Use Form

In the following spaces, please give a brief description of why you want each compounded cream and what you will be using it for.

Topical Pain/Migraine Management:

PAIN LEVEL									
1	2	3	4	5	6	7	8	9	10

Topical Wound Management:

Topical Eczema/Psoriasis Treatment:

I have eczema

Topical Burn Cream:

General Wellness Tablets:

Topical Nausea Cream:

Topical Migraine Cream

Topical Scar Therapy:

I have scars

Topical Stretch Mark:

I have stretch marks

Topical Nail Fungus Treatment:

Topical Anti-Aging/Wrinkle:

Topical Gout Management:

Psoriasis Treatment:

PATIENT SIGNATURE:

Alyssa Weber

DATE:

10/24/14

EVALUATION AGREEMENT

The undersigned agrees to evaluate Alyssa Weber, products that have been known to help some people treat certain skin issues or conditions. The undersigned acknowledges and agrees that no person or entity has made any guarantees or warranties of performance related to this product. The undersigned agrees that, if prescribed this product, he or she will use the product as directed by the prescribing medical professional, and will provide an evaluation of the product's performance.

In exchange for providing an evaluation, the undersigned acknowledges that he or she may receive financial payment. However, the undersigned also understands that payment is not conditioned on providing a favorable evaluation and that the undersigned is expected to make a fair and honest evaluation of the undersigned's personal experience with the product.

Alyssa Weber

HIGHLY CONFIDENTIAL

UNITED STATES UNIFORMED SERVICES



SIGNATURE

Alyssa Sue Weber

WEBER, ALYSSA SUE

SPONSOR

WEBER, NICHOLAS OWEN

EXPIRATION DATE

2015OCT25

SPONSOR SERVICE / STATUS

USA/AD

SPONSOR RANK / PAY GRADE

SSG / E6

DOD ID NUMBER

1157110698

RELATIONSHIP

SP

AUTHORIZED PATRONAGE

EXCHANGE MWR
COMMISSARY

DATE OF BIRTH

1985JUN16

BENEFITS NUMBER

012132529-01



DATE OF ISSUE

2014MAR28

MEDICAL

DIRECT: YES

CIVILIAN

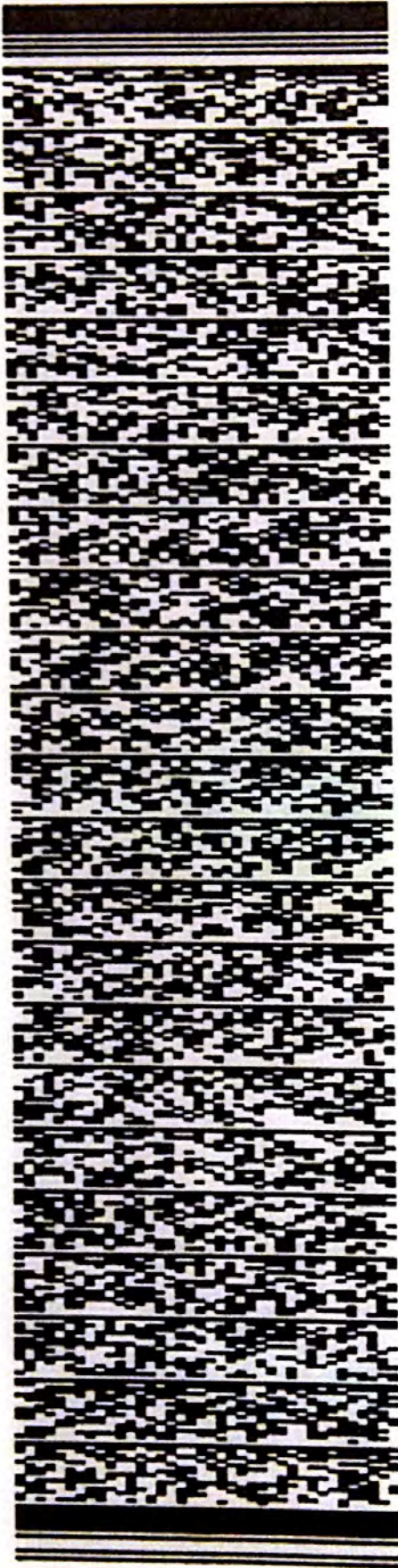
YES

EFF DATE

2009JAN27

EXP DATE

2015OCT25



DD FORM 1173

OCT 93

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OSD(P&R) OCT 2005